The **Stomatology** hospital is the only dental hospital in Afghanistan and is apparently carrying out faciomaxillary surgery. The director stated that aside from the general running needs, their main requirement was for specific dental supplies such as materials for fillings. It was not possible to assess the functioning of the hospital at the time of the initial visit and so further research is needed if this hospital is to be considered for aid.

Antani hospital is the only isolation hospital for adults. At the moment there are very few patients but apparently in the summer months it is so busy that some patients have to sleep in tents outside. Their facilities are limited with hardly any equipment. The water system was repaired by MSF when they rehabilitated Jamhuriat hospital next door. The hospital receives coal from ACTED and PSF have just started to give medicines and plastic covers for the beds. Within the grounds of this hospital there is a partially finished building which is empty except for the female laboratory. The director mentioned that the MoPH had asked him if this building could be used for tuberculosis patients. The issue of the location of the TB Institute and possible TB inpatients is still unresolved and will be discussed later in this report.

The **Psychiatric** hospital has not been visited. PSF supply some drugs and ACTED give coal, but otherwise little is known about this hospital. There is also a psychiatric clinic in another part of town that is said to be part of this hospital. Again more information is needed before assistance should be considered.

In all hospitals the nursing care is of a poor standard - this issue will be discussed later in this report.

5.1.4 Conclusion

Referring back to the two categories of need, the first category of general support should ideally be covered by the MoPH and it does not lie within the scope of MEDAIR's resources.

It is more appropriate for MEDAIR to consider the specific needs of individual hospitals, and in giving assistance to any one hospital, MEDAIR will also be providing for the general needs of that establishment.

The provision of care is adequate in surgery and medicine and does not justify intervention by MEDAIR.

However this is not the case for paediatrics and obstetrics and gynaecology. Afghanistan is reported to have the fifth highest childhood (under-five) mortality rate and the second highest maternal mortality rate in the world. While there are many influencing factors including health education, preventative care and general poverty, the lack of easily accessible curative facilities is an important contributing factor.

Of the three hospitals that provide paediatric care, Maiwand and Ataturk are functioning well and the Indira Ghandi is just coping with the mixture of support that it receives. At the moment there is no need for MEDAIR to intervene, but the situation should be monitored over time.

The area of hospital care most poorly addressed at the moment is that of obstetric care and gynaecology. Some of the options available for intervention are assistance to Malalai or Rabia Balkhi hospitals or to the polyclinics in the more peripheral areas of the city. AMI have submitted a proposal with the UN consolidated appeal to assist Malalai and are waiting for approval and funding. Rabia Balkhi is in district 2 in the centre of the city and not very far away from Malalai so assisting this hospital would not increase accessibility to many women. However Khair Khana polyclinic is in a densely populated area to the north of the city quite some distance from the centre and there is already an obstetric unit within the polyclinic, although it is only partially functioning.

It would therefore be worthwhile for MEDAIR to support this "hospital" with equipment, incentives for staff and food and fuel in order to provide obstetric care for the women in the Khair Khana area. It

would also be important to continue monitoring the situation and possibly consider assisting the other polyclinics in the future. This would allow for greater availability and accessibility of obstetric care and thus a reduction in maternal mortality. A detailed programme proposal has been prepared which is available upon request.

It seems that in the present circumstances the hospitals have little hope of sustainability without international aid. In view of the unstable political and economic situation it will be important for MEDAIR to continue monitoring all the hospitals. This is particularly true for those with little or no NGO support as their needs will inevitably increase.

5.2 Polyclinics

5.2.1 Description

Kabul used to have a system of 4 or 5 large polyclinics serving different areas of the city, set up under the Communist government. These contained general and specialist outpatients with laboratory and Xray facilities, dental care, obstetric facilities for complicated deliveries, and TB clinic, amongst other things. They were apparently well known and well utilised by the community, however in the past five years they have suffered from lack of funding and in some cases damage from bombardment. Four are still functioning at some level: Central, Rahmen Mena, Kushal Mena and Khair Khana polyclinics.

Now the term 'polyclinic' is also used for a wide range of clinics - anything from 1 room with a mid-level health worker to a large structure with several doctors in different specialities consulting, EPI and nutrition programmes, laboratory facilities and provision for inpatients.

Some NGOs use the classification C1, C2, C3 - standing for different sized clinics.

- C1 - comprehensive clinic with 1 or 2 doctors, a dentist, MCH facilities, laboratory and community health workers
- C2 - basic clinic with a mid-level healthworker and 2 or 3 community health workers
- C3 - basic health unit with 1 or 2 basic health workers

These terms tend to be used more at provincial and district levels and not within Kabul city. Most of the clinics discussed in this section would be classed as C1.

All of the clinics mentioned here lie within the public health care sector but there is no common policy regarding fees for services. Some clinics provide all services, including medicines, free of charge while some ask for a consultation fee and will only give a prescription for medicine which the patient then has to buy in the bazaar, essentially acting like a private clinic.

5.2.2 NGO involvement

These clinics may be run by the MoPH or MRRD or minority groups or by Afghan or international NGOs or by any combination of the above.

The NGOs assisting polyclinics are as follows:

- ARCS
- IFRCS
- Halo Trust
- KPRO
- MSF
- ORA
- PSF
- SCA

ARCS and through them **IFRCS**, run the following 9 clinics within the city.

1. district 2 Karte Parwan
2. district 4 Taimani
3. district 7 Chelsetoon
4. district 8 Rahmen Mena
5. district 8 Chama
6. district 10 Qala Fatullah
7. district 11 Khair Khana part 1
8. district 15 "500 Families"
9. district 16 Dehi Khodydad

These clinics are completely supported and supervised by ARCS and IFRCS. The staff receive a salary from ARCS and are not MoPH employees. Each clinic should have at least 1 doctor, 2/3 nurses, 1 pharmacist and 1 health educator. IFRCS provide medicine kits calculated to be sufficient for 45-50 patients per day for 1 month and are trying to encourage a shift from curative towards more preventative care with more emphasis on health education.

One of the best run ARCS clinics is the "500 Families" clinic in Khair Khana part 3. The staff number 10, with only 1 (female) doctor. They see an average of 50-60 patients per day, on a schedule of children 3 days, women 2 days and men 1 day per week. Health education is presented to all the patients in the waiting room before consultations begin.

Apparently the drugs sometimes run out before the next supply and so the doctor writes prescriptions for the private pharmacies. All consultations and medicines are free of charge in this clinic, although reportedly this is not the case in all ARCS clinics.

There is an EPI room with 2 vaccinators (not employed by ARCS) and a daily attendance of 10-15 mothers and children. In the same building ACF run a Supplementary·Feeding Programme for 2 days each week. There are 260 children in the programme at this time.

Halo Trust, an international demining agency, runs a small clinic in Qala Fatullah. This provides a curative service free of charge. Since September 1996 they are only able to see women and children as the doctor is female. They see 70-80 patients per day and plan to open a simple laboratory service in 1997.

KPRO support a comprehensive clinic in Deh Sabz, in the eastern part of Kabul province, with mobile EPI to the surrounding villages.

MSF supports 5 clinics, within or on the outskirts of the city and one other clinic approximately 35 km south of Kabul.

1. district 4 Taimani
2. district 6 Dashte Barchi
3. district 12 Arzan Qimat (started Dec. 96)
4. west of city Paghman
5. south of city Charassyab
6. 35 km south Mohammed Agha

They provide incentives for 7-9 staff in each clinic. Some of the clinics are under MoPH, while others were previously run by the Hezbi-e-Islami or Hezbi-e-Wahdat parties and are still not registered with MoPH and therefore the staff do not receive any salary from MoPH. One clinic is privately run by the minority Ismaili community.

Most of these clinics have inpatient facilities for 10-20 patients, some are used much more than others. There is usually a doctor on call for the clinic 24 hours a day. Some of the clinics have a vaccination room (managed by UNICEF), none of the clinics have health educators. All consultation, medicines and laboratory tests are free of charge. Treatment for Leishmaniasis is provided in 2-3 of these clinics, on an individual basis and very closely supervised by the MSF expatriate doctor.

The clinics are visited weekly by the MSF expatriate doctor. MSF have found that the clinics in the Hazara areas (Dashte Barchi and Paghman), and the Ismaili clinic in Taimani are well run and the staff are committed, whereas those in Charassyab and Mohammed Agha have not provided such good care. MSF are considering stopping their support of the latter clinic, citing poorly motivated staff and lack of co-operation as the main reasons.

The clinic in Dashte Barchi is in a former military compound, now shared with an ACF therapeutic feeding centre. There are two male doctors and 3 nurses. They have 7 female and 5 male inpatient beds and a small laboratory. There is a fixed EPI centre in the clinic, managed by UNICEF and MoPH.

When the fighting was concentrated to the south of Kabul city earlier in 1996, the clinic in Charassyab was used as a small surgical hospital and then a first-aid post by ICRC. Now it is functioning on a minimal level with consultations by male doctors only, nursing care for dressings and occasional 24 hour admission for emergencies. There is no female doctor, no health education and no EPI. Although MSF pay incentives for only 7 people, the clinic director reported having 35 members of staff.

The clinic in Mohammed Agha is run by two male doctors who apparently see up to 90 patients per day. They have separate OPD rooms for men and women and 9 inpatient beds. They commented that the monthly supply of medicines from MSF only lasted for 15 days, after which they wrote prescriptions for the patients to buy. They have no health education or EPI in the clinic.

ORA fully support a polyclinic in Pul-e-Cherki (district 12) and give some assistance to the TODAI clinic in district 10.

PSF assist about 12 other clinics run by the **MoPH,** the **MRRD** (Ministry of Rehabilitation and Rural Development), and other political groups with pharmacy rehabilitation, training for the pharmacist and a monthly supply of medicines.

Three polyclinics - Central, Khair Khana and Rahmen Mena are supplied with medicines by PSF. ACF run a feeding centre in Kushal Mena polyclinic. As mentioned in the hospital section, SC(US) are running the ARI programme in Khair Khana polyclinic, but apart from the above these original polyclinics do not receive any other help

SCA do not have any clinics in the city but they support about 20 clinics of various sizes around Kabul province.

5.2.3 Issues / needs assessment

Kabul city appears to have enough general clinics, especially as in addition to this many of the hospitals have outpatient facilities which work just like polyclinics. The districts 2, 9 and 15 have the least clinics for the size of population residing there. As can be seen on the map in Appendix B, for the people in district 2 there are clinics and hospitals close by in district 4, and the same applies for districts 9 and 10, but for those in district 15 it is quite a distance to travel to reach other public health structures. Khair Khana polyclinic is in district 15 and if given support could provide more comprehensive health care for this densely populated area which has no other hospitals and only one other general clinic.

The main problem that the doctors in the clinics mentioned was an insufficient supply of drugs. Most NGOs supply according to generally recognised criteria for a given population using only "Essential Drugs" and it seems more likely that the real problem is overprescribing. This appears to be a widespread practice in Afghanistan. There is a very high expectation from the patients to be given at least two or three different types of medicine at each consultation and this expectation is continually reinforced. Education would be the main way to try to counter this practice. The education of doctors and pharmacists would have to be started during their initial training and continued throughout their practice. This needs to be complimented by education for the community, for example in schools and clinics, or through the mass media. Whichever way this is tackled, it is a long-term issue.

5.2.4 Conclusion

Kabul is well provided for and does not require any further polyclinics. However the existing polyclinics in districts 1, 5, 8 and 15 would benefit from outside assistance. This is certainly the case for Khair Khana, as discussed above. The situation for the other clinics is less clear and more information is needed. MEDAIR could support Khair Khana polyclinic with the provision of some equipment, food and fuel for inpatients and incentives for the staff, with monitoring and management assistance, and training if necessary. This ties in well with the observed need for maternity services as discussed in the hospital section.

5.3 Mini health centres

Started by **UNICEF** in 1992 as a first aid post for the communities, these were comprised of health and nutritional education, supplementary feeding, treatment for seasonal diseases i.e.: diarrhoeal disease in the summer and acute respiratory infections in the winter. UNICEF supplied simple drugs and training and more recently, incentives for the staff seconded from MoPH. The communities supplied the clinic room. UNICEF have reviewed the activities of these mini-health centres and have stopped their support as from September 1996 as many were not functioning anyway (the staff were busy with their private clinics and there were no patients attending). They are intending to integrate the remaining staff into the MCH and polyclinics in each area, perhaps with some outreach activities.

This type of health intervention is no longer considered appropriate for the situation in Kabul, where there are so many other facilities available.

5.4 MCH (Mother and Child Health) clinics

5.4.1 Description

In the past the MoPH had established a network of MCH clinics throughout the city although it is not clear how well they were functioning. During the last 4-5 years of intense fighting in and around Kabul some of these clinics, particularly in the south of the city, were destroyed or the buildings requisitioned for military purposes. However many of these clinics are now supported in some way by NGO's. Most of the MCH clinics without NGO support are functioning on a very minimal basis.

Theoretically all MCH clinics should provide antenatal care and monitoring, curative care for mothers and children, growth monitoring of children, health and nutritional education and vaccination for mothers and children and family planning. Some of the clinics also have feeding centres attached.

5.4.2 NGO involvement

The following agencies are assisting MCH clinics in different ways:

- AMI
- AVICEN
- IAM
- MDM
- TDH
- ACF
- UNICEF (EPI)
- [OXFAM]
- [SO]

AMI support 10 MCH clinics in the following locations

1. district 4 Parwan Seh
2. district 6 Qala Wazir
3. district 6 Qala Bakhtyar

4. district 9 Shash Darak
5. district 10 Char Qala Wazir Abad
6. district 10 Bibi Mahro
7. district 15 Khair Khana part 2
8. district 15 Khair Khana part 3
9. district 15 "500 Families"
10. district 16 Qala Zaman Khan

Their support has included rehabilitation of buildings, training for the staff, supply of medicines and supervision of daily activities (1 or 2 expats and 5 Afghan supervisors). Many of these clinics provide a reasonable service. Up until the present time AMI have not paid incentives to the staff, but in the last month have decided to pay incentives on a scale agreed between them and MSF, ACF, MDM and AVICEN. The reasons for this are that because the MoPH has not paid any salaries for 2 months, many people have lacked motivation, often not attending for work and the quality of work was definitely deteriorating.

The clinics vary in size. The clinic in Khair Khana part 3 had no laboratory, but did have a vaccinating team. Apparently one member of this team visits the houses around the area to remind mothers to bring their children to the clinic. Health education is given to the mothers as they wait, by different nurses or vaccinators. There is no specific health educator. The majority of the staff are female.

AVICEN support 8 MCH clinics in Kabul; the first 2 run completely by the NGO and the other 6 in co-operation with MoPH.

1. district 6 Dashte Barchi (Bibi Fatimah clinic)
2. district 10 Qala Fatullah (Zarghuna clinic)
3. district 4 Shahrara
4. district 6 Ghul Khana
5. district 8 Rahman Mena
6. district 9 Microrayon 3
7. district 10 Prodje Wazir Abad
8. district 11 Khair Khana 1

AVICEN pay incentives to the staff in the first two clinics only. The staff in these two clinics are not MoPH employees and do not receive any other salary. AVICEN does not have sufficient funds to pay incentives to the other 6 clinics but give occasional performance related "rewards". The number of staff varies, for example the clinic in Microrayon has 4 obstetric doctors, in Ghul Khana there is one doctor and in Rahman Mena there are hardly any staff. Reportedly, in AVICEN clinics all the staff are female except some of the vaccinators.

The facilities provided are reception and records, consultations for mothers and children, health and nutrition education, first aid & dressings, simple laboratory tests, vaccination and pharmacy. All of these are provided free of charge.

They also have a scheme for "Voluntary Health Sisters", on average about 15 per clinic, who are trained in health education. Since the Taliban take-over many of these women have apparently remained in contact with the clinics but some are not working. In November 96 twenty Voluntary Health Sisters from Dashte Barchi and Gul Khana took part in a training course run jointly by MoPH, UNICEF, WHO and AVICEN.

IAM run one busy MCH clinic in Karte Seh, district 6, closely supervised by 2 expatriate staff. They see 60 children and 60 mothers per day. The health educator speaks to the mothers as they wait for their turn. Consultations with a doctor, vaccination for mothers and children, family planning, simple laboratory tests are all provided free of charge, although there is a small charge for the "Road to Health" card, to try to remind the mothers of the value of keeping it safely. There is also a nutrition programme for under 2 year olds with supplementary feeding and cooking demonstrations for the

mothers. Malnourished children over 5 years are referred to the nearest ACF supplementary feeding centre. Tuberculosis treatment is provided for 50 patients per year, mostly children.

MDM presently support one MCH clinic in Pul-e-Sokhti, district 6. This is a Hazara community and the clinic was previously under Hezbi-e-Wahdat, therefore the staff are not MoPH employees. MDM pay incentives for the staff. The facilities provided are paediatric and gynaecology consultations, a feeding centre for up to 30 children and follow-up consultation for 200 malnourished children at any time. MDM supply medicines (from PSF) and food for the feeding centre. On average there are 50 child consultations per week.

For 1997 MDM plan to support the following additional MCH clinics.
1. district 7 Wasalabad
2. district 5 Deroye Paghman
3. district 15 Khoja Boghra

TDH do not support any individual MCH clinics but since January 1996 have run an excellent MCH-Home Visiting Programme with 10 midwives visiting homes in 5 areas. These are midwives who have already had a 2-3 year training. TDH gave them a 4-week refresher course then assigned 2 midwives each to an MCH in their area. All the MCH clinics chosen are MoPH clinics receiving support from other NGOs. The midwives spend the morning visiting (by foot) houses in their area where there are pregnant women or postpartum women. They refer the pregnant women to the MCH for antenatal care and tetanus vaccination. They monitor the condition of the postpartum women and the newborn babies until six weeks after delivery and refer for BCG vaccination. They carry basic drugs to treat infections, pain and anaemia which they give free of charge. They are also available to carry out home deliveries in their area when requested. Each home visit includes health education and support for breastfeeding. The midwives pick up cases by word of mouth, knocking on doors, following pregnant women until delivery, referral from MCH and their own home deliveries.

The programme is running from the following clinics:
1. district 4 Shahrara
2. district 4 Parwan Sewom
3. district 9 Shash Darak
4. district 10 Bibi Mahro
5. district 11 Khair Khana 1

An assessment of the programme was carried out in August 1996 and concluded that the refresher course was appropriate and helpful and that diagnosis, treatment or referral of complications was appropriate. The complications diagnosed and dealt with most frequently were:
- Antepartum: vaginal bleeding, vaginal haemorrhage, UTI
- Intrapartum: prolonged labour and preeclampsia
- Postpartum: endometritis, hypertension and postpartum haemorrhage
- newborn: URTI, jaundice, septicaemia, omphalitis

Intervention in many of these cases may well have been life-saving.

TDH are presently running a refresher course for 6 more midwives to work in 3 new areas
1. district 6 Qala Wazir
2. district 15 Khair Khana 3
3. district 16 Qala Zaman Khan

Further plans are to expand in the spring of 1997 to 2 more areas, probably in the south of the city.

ACF presently run feeding centres in many MCH clinics (full details in Nutrition section) and for 1997 are planning to support 4 MCH clinics in Kabul with incentives for the staff, equipment and medicines. Possible clinics are located in Dughabad, Binyasol, Alawuddin (all in district 7) and Paghman (west of district 5).

UNICEF support the EPI programme in Kabul, with fixed vaccination centres in most MCH clinics (full details in EPI section). They also provide technical assistance to the MCH department in the MoPH for example in planning and implementing the "Safe Motherhood Initiative" (although it is unclear what this actually involves).

OXFAM were planning to fully support 6 MCH clinics in districts 1,3,7 and 8. This would involve construction of new buildings, supply of equipment and medicines and training of staff. However since October 1996 OXFAM have suspended their Kabul projects due to the restrictions on the employment of women. It is not at all clear whether they will be able to start these clinics and if so, when.

The **Shuhada Organisation**, an Afghan NGO, apparently run one MCH clinic in district 6 but no detailed information was available. Their main office is in Quetta, Pakistan.

5.4.3 Issues / needs assessment

If the present support from NGOs continues and they are all able to implement their plans for 1997, Kabul city will have a good network of MCH clinics providing curative and preventative health care for women and children.

The areas of the city which are not so well covered are districts 1 and 2. District 1 has one clinic for an estimated population of 45,000 and district 2, with a population of 66,000 has none. There are two clinics close by in district 4 but they are also serving the (unknown) population of that district. (See map in Appendix A). District 7 has suffered severe war damage and presently has a population of around 20-30,000. People have begun to return to this area but not in great numbers as there are few inhabitable buildings. In 1997 MDM plan to assist one clinic and ACF plan to assist three, all within district 7, so there should be adequate coverage there even if many people return. It is not clear why districts 1 and 2 have had less attention.

Outside of the city there are no MCH clinics. Some towns and villages have health centres which provide some care but there are no facilities specifically for women and children and in particular no preventative care apart from occasional vaccination centres.

Health education is covered very well in some clinics but minimally in others.

5.4.4 Conclusion

Afghanistan has very high under-five and maternal mortality rates and therefore specific curative and preventative care for mothers and children should have a high priority in the provision of health facilities. Kabul already has good coverage with around 35 MCH clinics, of which at least 29 have or will receive some support from NGOs. In addition the midwives home visiting programme runs from 5 of these clinics and a further 5 in 1997.

There are a few geographic area where MCH coverage appears inadequate. However intervention, if appropriate, should be by an NGO already running MCH clinics.

MEDAIR should look at providing MCH facilities in areas outside of the city, within Kabul, Wardak, Logar and other provinces. Up until this time it has been difficult to identify any particular town or village where MEDAIR could support an MCH clinic in co-operation with the MoPH (in part because the relevant people were absent from the MoPH) and further research is needed in this area.

5.5 Nutrition

5.5.1 Description

Although there is always food available in the bazaars in Kabul, the ability of families to purchase it is limited due to the high cost, poor wages and high inflation. The situation generally becomes worse during the winter months and many families resort to selling their belongings or borrowing money in

order to survive. With women now forbidden to work the situation has worsened for the estimated 40,000 widow-headed households.

Anthropometric surveys in the under-fives carried out by ACF during 1996 showed:

- total malnutrition rate 6%
- severe malnutrition rate 1.8%

UNICEF convened a workshop with the involved NGOs in nutrition in Peshawar in October 1996 and the collated results from 9 surveys in Kabul and Jalalabad showed:

- total malnutrition rate 2.6-11%
- severe malnutrition rate 0.6-2.3%

Apparently these figures show an improvement from previous years and there is little seasonal variation, despite the increase in diarrhoeal diseases in the summer.

5.5.2 NGO involvement

The agencies with nutritional programmes include:

- WFP
- ACF
- [UNICEF]

In addition to this ICRC, CARE and ARCS are involved in the Winter Relief food distribution to widows and other vulnerable people, covering the whole city between them.

WFP in partnership with ACTED and other agencies have subsidised 95 bakeries throughout the city to provide a daily ration of bread for widows, disabled and other vulnerable groups, but the scheme is apparently corrupt in some areas. It certainly does provide help to 120,000 beneficiaries although the selection procedure is dubious.

WFP also supply food to hospitals in the form of wheat flour, ghee, sugar and lentils. Most of the hospitals report that the quantity is insufficient and request rice and salt in addition.

ACF run a nutritional programme for children under 5 years with Supplementary Feeding Centres (SFC) where the children are monitored and receive a weekly dry ration and Therapeutic Feeding Centres (TFC) which are either 24 hour care in hospital or full day attendance for 6 meals at a clinic centre. At all centres the mothers are given nutritional education and shown how to cook the dry ration. Experience has shown a high default rate from the hospitals because of the difficulties for the mothers with transport and caring for the rest of their family, so ACF are in the process of developing more of the SFCs into day-care Therapeutic centres. By the end of December 1996 they aim to have 16 SFCs, 14 or 15 day-care TFCs and continue the 24 hour TFCs in Attaturk, Indira Ghandi and Maiwand hospitals. All the feeding centres are based in either MCH or polyclinics where some curative care can be available.

ACF have repeatedly surveyed the levels of nutrition in the under 5 year olds and women of childbearing age and are presently conducting a joint anthropometric and socio-economic cluster survey in Kabul city. Their intention is to identify nutritionally vulnerable populations, and to try to discover the reasons for poor nutrition, whether economic difficulties, poor weaning practices or lack of education. Also to look at the coping mechanisms that people employ in times of economic hardship. The results of the anthropometric survey should be available by the end of January 1997, the other aspects of the survey will take much longer to analyse. No great changes are expected from the figures quoted above.

UNICEF were previously supplying high energy biscuits to the mini health centres and several other clinics, but this has now been discontinued.

5.5.3 Issues / needs assessment / conclusion

The nutrition status of the population is well addressed by the activities outlined above and there is no need for involvement by MEDAIR.

5.6 EPI (Expanded Programme of Immunisation)

5.6.1 Description

Taking into account the huge difficulties in compiling accurate data for a country fragmented and destroyed by years of civil war, UNICEF give the following figures for immunisation coverage for the whole of Afghanistan for 1992 - 1995.

- BCG 31%
- DPT(3) 41%
- polio 56%
- measles 41%
- tetanus 3% (women of child-bearing age)

In June and July 1996 two mass immunisation campaigns were carried out by MoPH, UNICEF, WHO and NGOs. Over 2.4 million children were vaccinated with the following uptake:

	OPV	DPT	Measles	TT
1st round	87%	71%	-	126% (?)
2nd round	88%	73%	74%	135% (?)

These figures were taken from the WHO publication "Hope". UNICEF in Peshawar are presently preparing their statistics for the complete vaccination coverage for Kabul and Afghanistan, and they should be available later in January 1997.

5.6.2 NGO involvement

Within Kabul city and province the **MoPH** and **UNICEF** are responsible for all immunisation schemes. There is now a central vaccine cold storage facility in Kabul and 47 fixed vaccination centres in the city. The staff are all MoPH employees but receive incentives from UNICEF. The plans for 1997 are to have all the mothers and children going to the same clinic for all their vaccinations to enable more accurate record keeping. There will be a public awareness campaign on radio to inform people. From a conversation with the staff of one EPI centre this does already seem to be happening to a certain extent. Also where there are areas of the city with patchy clinic coverage the EPI staff will do mobile outreaches from the fixed centres.

In the districts outside the city there are only 29 fixed centres and some villages have only been reached during the mass campaigns. In these areas too it is planned to have mobile outreaches.

5.6.3 Issues / needs assessment

ACF carried out a survey of vaccination coverage within the city in November 1995 and the results of this are as follows:

- BCG 77.9%
- DPT3/ Polio 42.7%
- Measles 14.9%

However since then there have been two mass immunisation campaigns in June and July of this year with a good uptake, so the true coverage is likely to be higher.

1. Executive Summary

Afghanistan has a poor health record with very high infant, childhood and maternal mortality rates and an average life expectancy of 44 years. The greatest causes of mortality are diarrhoeal diseases, malaria and tuberculosis.

Kabul city has suffered extensive damage during the past 4 years of fighting and, as a result, severe disruption of its medical services. The incidence of communicable and vector-borne diseases has increased significantly.

The Ministry of Public Health lacks resources and consequently is unable to respond in any significant way to these huge needs, or to effectively coordinate and monitor activity.

Kabul presently has 22 hospitals, 26 general clinics, 33 MCH clinics, 7 specialist clinics and 30 feeding centres. Many of these are heavily supported by NGOs and would not be able to function without their support.

Whilst provision for surgical and medical hospital care is good, paediatric care is likely to deteriorate and obstetric/gynaecology care is very poor. Some districts within Kabul are poorly covered for curative services, notably the densely populated north-western districts.

The network of MCH clinics is extensive and well supported by NGOs within Kabul. However, there are no MCH services outside the city.

Curative facilities are generally available for diarrhoeal diseases and malaria, the 2 greatest causes of mortality. However tuberculosis treatment and control is much more complex and poorly addressed by the existing structures, because of inadequate resources.

The main recommendations of this report are that MEDAIR should assist the Tuberculosis Institute, in order to improve treatment and control of tuberculosis, and the Khair Khana polyclinic, in order to improve paediatric, obstetric and gynaecology care and improve geographic coverage of curative services. Section 7 provides a complete list of all unmet needs and appropriate responses.

It would certainly seem that measles coverage is higher as none of the hospitals or clinics have reported more than 2 or 3 isolated cases of measles in the past year. The same is true for polio cases. However full tetanus coverage for women still seems to be only around 6% (UNICEF).

5.6.4 Conclusion

There are a good number of EPI centres throughout the city and although there are less in the rural areas, UNICEF and the MoPH are taking measures to increase the coverage. There is no need for MEDAIR involvement.

5.7 Specialist facilities and programmes

5.7.1 Description / NGO involvement

Afghanistan used to have large vertical programmes for the control of malaria, leishmaniasis and tuberculosis with national institutes in Kabul and regional centres around the country.

5.7.1.1 Tuberculosis

In the 1980's the **TB Institute** had extensive support from the Japanese government, UNDP, WHO and UNICEF who financed the building of a well equipped centre and sanatoria for men and women. Children were admitted to Maiwand hospital. However in the years of civil war and particularly the past 4 years of fighting in Kabul all these buildings had been destroyed and the TB Institute was closed.

In April 1996 **WHO** supported the MoPH in the restarting of the TB Institute with the provision of some drugs and laboratory supplies. The Institute has treated a limited number of patients (around 500) since then. They use two treatment regimes: 8 month short course treatment with 4 drugs for sputum positive and seriously ill patients and 12 month standard regime with 3 drugs for all other cases. There has been little monitoring of the programme and drugs that ideally should be given on a daily basis have been given out for 15 to 30 days with no way of effectively checking that they are being taken. Of the patients presently on treatment 22% have sputum positive and 52% sputum negative pulmonary TB and 26% have extrapulmonary TB. WHO recommendations for TB control programmes are that sputum positive patients should constitute more that 50% of patients on treatment and the aim of the programme should be to cure 85% of all sputum positive cases. It is too early to have any cure rates for the TB Institute as the programme has not been running for long enough.

The Institute has recently moved location and now shares a building with the Institute of Malaria and Parasitology and a psychiatric clinic in the centre of the city.

TB treatment is also provided by the **German Medical Service** clinic beside Wazir Akbar Khan hospital. This NGO has been providing leprosy treatment for many years in Kabul and in 1993 started to also diagnose and treat tuberculosis in their clinic. GMS use 6 or 8 month short course treatments for all cases. They also have about 500 patients on TB treatment and give food from WFP as an incentive for the patients to complete the course. Of these patients 30% have sputum positive and 38% sputum negative pulmonary TB and 31% extrapulmonary TB. Over the three years treatment has been completed by 60.5% of all patients registered. This is below the WHO target of 85%.

IAM took over the care of some TB patients when the GMS clinic moved from Jamialiad in the south of the city. One lady doctor is seconded from the TB Institute to the MCH clinic in Karte Seh and she diagnoses and treats up to 50 patients per year, mostly children. She uses the same treatment regime as the TB Institute.

5.7.1.2 Malaria, Leishmaniasis

The Institute of Malaria and Parasitology is not supported by any international NGO (other than laboratory reagents from WHO).

A Japanese agency, **TODAI**, run a clinic in Wazir Akbar Khan (district 10) for malaria and leishmaniasis. They have very selective treatment criteria as they do not have enough glucantime to treat all the patients that they see.

In addition the dermatology department in Maiwand hospital see many patients with leishmaniasis, but can usually only give a prescription for the patient to buy in the bazaar.

5.7.1.3 Leprosy

WHO provides Maiwand with Dapsone and Rifampicin to treat leprosy cases.

GMS continue to treat a small number of patients with leprosy and check up on those who have completed treatment.

5.7.1.4 Others

Orthopaedic and physiotherapy services, particularly for amputees, are provided by **ICRC** and **Sandy Gall's Afghanistan Appeal,** both of whom have workshops beside Wazir Akbar Khan hospital. **IAM** runs a physiotherapy training school.

IAM support the Noor eye hospital, an ophthalmology unit in Maiwand hospital and clinics in other hospitals. Outreach "eye camps" are run in other areas of the country by staff from Noor hospital. They also assist with rehabilitation and training for the visually impaired.

AVICEN support the central blood bank which co-ordinates blood donations and related services for the city. They have blood bank units in 7 hospitals (but not all functioning). 'Voluntary' blood donors are given 4 bags of coal per donation as an incentive.

AMI are proposing in 1997 to assist the Central Laboratory as a referral and supply centre for all the clinic and hospital laboratories in Kabul.

5.7.2 Issues / needs assessment / conclusions

According to WHO statistics for all of Afghanistan, malaria is the second highest cause of mortality followed by tuberculosis.

Malaria is more of a problem in the eastern provinces and less so in Kabul although TODAI report that the number of cases, particularly of Plasmodium Falciparum, the most serious form, are increasing. The treatment for malaria is relatively simple and can be administered in almost any health facility, so any NGO intervention should perhaps focus more on prevention of infection and control of the vectors. **HealthNet International and IAM** have written separate proposals for the control of vector-borne diseases including treatment, health education, supply of bednets and clearance of vector breeding sites. The IAM project is aimed more at the problems of leishmaniasis but would also have an effect on malaria transmission. However at the time of writing, neither of these projects is running in Kabul.

Tuberculosis is a much more difficult disease to treat as it requires three or four drugs to be taken for 6 months minimum and this treatment must be closely monitored. In times of instability and large population movements this becomes even more problematic and in Afghanistan, during the years of war the national programme completely disintegrated and the facilities in Kabul were destroyed. With the poverty and overcrowding of displaced people the incidence of TB is very likely to have increased and as stated above it is the third highest cause of death in the country. WHO have started 8 pilot projects around Afghanistan for TB treatment, one of these being with the TB Institute in Kabul. These projects are not being well monitored by WHO due to a lack of resources. However the Institute and MoPH would like to expand the programme to other clinics around the city, thereby increasing the access of patients to the clinics which should make it easier to closely monitor treatment and increase compliance. WHO have a small budget which is almost exhausted and PSF have been asked to supply the drugs for these clinics. PSF is willing to consider this if another NGO could supervise the programme. MEDAIR could take this place in assisting the TB Institute with rehabilitation of buildings, supply of

laboratory equipment and reagents, training and supervision of the laboratory staff, incentives for staff in the Institute and smaller clinics, starting up daily treatment and defaulter tracing and management assistance. A detailed programme proposal has been completed for TB control in Kabul - this is available upon request.

5.8 Private health care facilities

There are numerous private clinics, pharmacies and laboratories within Kabul. The MoPH salary for a doctor (when it is paid) is equivalent to about US$ 6-10 per month and is not enough to support a family. Therefore most doctors also work in a private clinic in the afternoons where they charge a small fee for consultation and give prescriptions for the patients to buy in the private pharmacies. Some doctors have grouped together and run small private hospitals, for example the Maryam and Alnisa (Zaineb) clinics in Khair Khana, where they are able to do operations and provide inpatient care.

In all these clinics there is a strong tendency to overprescribe and most patients will be given a prescription for a minimum of 2 drugs, often more. There is a high expectancy amongst the population that a "good" doctor will prescribe like this, and the practice and the expectancy continue to feed on each other.

Most hospitals have only basic laboratory facilities due to a lack of equipment and reagents, however the private laboratories are able to do tests unavailable in the hospitals such as the Widal test for typhoid fever and the test for Brucellosis. On average each of these tests would cost between 20-30,000 Afghanis.

X-rays and ECGs are easily available if the patient can afford it, usually about 10-20,000 Afghanis for an Xray. There is no public hospital with an ultrasound machine for diagnosis yet there are 4 private ultrasound clinics within the city apparently with varying levels of expertise at reading and interpreting the results.

Private pharmacies abound. According to Habitat statistics in some districts there are almost as many pharmacies as there are bakeries. Many people will go directly to the pharmacist without consulting a doctor and buy what the pharmacist recommends. As might be expected, one can sometimes find drugs donated by various NGOs to hospitals and clinics on the shelves of the private pharmacies.

The cost of a simple course of antibiotics may be around 9,800 Afghanis, for a course of chloroquine (for malaria) maybe 200 Afghanis. For an 8 month course of antituberculosis treatment with three drugs initially, then a continuation phase of two the cost may be around 2,500,000 Afghanis (US $104 at present exchange rates).

There are no government regulations for or monitoring of these private facilities and the qualifications of the staff involved. In addition the poor salary for government work and the much better financial returns from private practice do not encourage excellent medical practice in the public sector.

6. Other Specific Issues

6.1 The gender issue

A new issue that has arisen for the people of Kabul with the Taliban in government is that of the denial of access to education and employment for women. This has had a big impact on many governmental offices, NGOs and UN agencies who had many female employees. The official orders from the Taliban leadership are that women are allowed to work in the health sector, but this is interpreted in varying ways down the chain of command.

In most hospitals and clinics women are now allowed to work so long as they are careful to wear the Islamic "hijab", i.e.: keeping completely covered except for eyes and hands. A greater problem has been that doctors are not permitted to see patients of the opposite gender. Hospitals and polyclinics have had to provide separate examining rooms, waiting rooms, and in some cases even laboratories for men and women. In Karte Seh medical hospital, for example, they have had to build new rooms onto the outpatients and the one female doctor is overloaded with work that was previously shared out amongst her male colleagues. In some clinics, including some MCH clinics, there are only male doctors, who may or may not be willing to defy the regulations. Even if they speak with the female patients they are very unlikely to give them any physical examination.

All of these problems are relatively new and solutions are still being explored by NGOs and the MoPH. One of the implications for new programmes is that additional staff and buildings may well be required and need to be planned for.

6.2 Training

6.2.1 Description

Kabul University has a faculty of medicine which had been functioning until September 1996, at which time the university was closed. No-one knows when it will be allowed to start up again, although there have been vague statements about universities opening again in the spring of 1997. It seems to be a fairly safe assumption that women will not be allowed to attend.

Postgraduate training for doctors is apparently continuing in the different specialist hospitals, although some senior doctors have recently left Kabul.

For paramedical disciplines there is an Institute of Intermediate Medical Training (IIMT), situated behind Wazir Akbar Khan hospital. This institute is one of 8 similar training schools in Afghanistan. Students are accepted from ninth or twelfth grade for 2 or 3 years training in the following vocations:

- laboratory technician
- laboratory officer
- Xray technician
- radiographer
- ophthalmic technician
- nurse (male and female)
- midwife
- dentist
- sanatarian (like a public health officer)
- assistant pharmacist
- physiotherapist

Theoretical training is given in the institute and practical training in appropriate hospitals, polyclinics and the environmental health department of the MoPH. The staff are MoPH employees and the tuition is apparently free. After the Taliban took over Kabul all female staff and students were ordered to stop

attending. This was only two and a half months before the students in the third year were due to take their final exams. The Institute lost 65% of its teachers and 40% of its students. Due to this the nursing/midwifery course has been stopped. In addition to this the Director left in October and his deputy left in December and reports suggest that neither of them will return. The school is now closed for the winter and due to reopen late March.

Traditional Birth Attendant (TBA) training has been provided by UNICEF and NGOs but there was little information available about this.

6.2.2 NGO involvement

Little information was gathered about the Faculty of Medicine or what assistance they have received. Dr Harry Jeene of **RALSA** has been involved with the undergraduate and postgraduate training.

As far as postgraduate training is concerned, many NGOs such as **ICRC, MSF** and **MDM** have included surgical, anaesthetic and nursing on-the-job training as part of the package of support given to hospitals. The same is true for a few clinics and the NGOs supporting them. **IAM** were conducting surgical training in Jamhuriat hospital, but the surgeon who was running this has left. IAM are also involved in training eye surgeons at the Noor Eye hospital.

MRCA have been running postgraduate medical training courses in Peshawar since 1986, and in mid-1996 started a plastic surgery unit with training for young surgeons to Maiwand hospital in Kabul.

The IIMT has received assistance from several NGOs. In 1993 or 1994 International Medical Corps (IMC) refurbished the Institute and supplied some equipment as well as running training workshops for the teachers and practical experience in Qarabagh hospital. IMC no longer has an office or programme in Kabul.

IAM run the physiotherapy school and train the eye technicians for the IIMT.

UNICEF, WHO, MoPH and **AVICEN** have conducted joint training courses for TBAs in Kabul.

6.2.3 Issues / needs assessment

For the Medical Faculty the main issues are whether it will open again and whether women will be allowed to enter. At the moment there are quite a few women doctors still in Afghanistan but if no women are permitted to study medicine, a critical shortage of female staff to treat women pateinets will emerge. There is some thought that in time the Taliban may become more lenient, but there is not much evidence of this in areas such as Kandahar which they have controlled since 1994. This issue will have to be monitored closely.

The above issue also applies to the IIMT, but in addition to this the Institute has been left with no-one in leadership and so again it is very unclear what will happen in the next semester. The deputy director had apparently met with the Deputy Minister of Public Health to try to find an acceptable way to reopen the midwifery school but he met with no success. The building appears to be run down with poor facilities or equipment, which is a little surprising as they were assisted so recently by IMC. There is also apparently a student dormitory in the west of the city which is very damaged but was still being used by the students from outside of Kabul.

6.2.4 Conclusion

Training of doctors, nurses, midwives and other paramedical workers is essential for the continuation of health care in Afghanistan but this area appears to have suffered a very large setback with the Taliban in power. Optimistically viewed there is still a possibility for a change in their attitudes and as they settle into government pragmatism may win over the present hard-line policies. The NGO role in this may be to constantly remind the government of the need for continued training, especially of female staff.

MEDAIR should certainly investigate the possibilities for assisting in the training of nurses and midwives and the situation at the IIMT will be followed closely, but as yet no firm proposals can be made given the absence of leadership and the present attitudes of the government.

6.3 Nursing care

Many of the NGO workers here have observed that nursing care is of a low standard and that nurses, and even more so traditional birth attendants, have a very low social status. The concepts of complete patient care are very foreign. The patient's family provide much of the basic care while nurses administer injections or infusions and sometimes change dressings. General monitoring of the patient's condition often does not take place. In particular nursing management is almost non-existent and this adds to the poor care given in hospitals.

In their support for the hospitals, ICRC, MSF and MDM have usually included some form of nursing supervision and sometimes short training courses. In addition IAM and GMS provide specialist nursing support through two experienced expatriates in Aliabad and Wazir Akbar Khan hospitals respectively. There is no other NGO involvement in nursing care or training in Kabul. MSF ran an assessment of the nursing care in the surgical wards of Jamhuriat hospital and concluded that it was of an acceptable standard, however this did not include the medical wards where there is less NGO input.

In none of the hospitals visited nor in discussions with officials of the MoPH was nursing mentioned as an area of health care requiring intervention.

In conclusion there is definitely a perceived need by the international NGOs for some input in the area of nursing care, but less so from the Afghan side. MEDAIR should certainly consider training and management support for nurses in any health structure that it supports (notably Khair Khana polyclinic and the TB Institute) and in addition should continue to pursue possible involvement in the IIMT.

6.4 Health education

The approach to health education in Kabul appears to be extremely variable. For example the IAM and AVICEN supported MCH clinics and ARCS clinics have a member of staff who's defined task is health education for the mothers attending the clinic. In AMI supported clinics several members of staff take on the task of health education besides their other jobs. In MSF supported general clinics there is no specific health teaching for the waiting patients. Of course in general it is the task of every health worker to explain and teach good hygiene, nutrition, the recognition and proper treatment of minor illnesses, etc. to the patients but in practice this is often neglected, especially in a busy clinic.

SC(US) have recently started an ARI programme in 5 hospitals which includes specific health education about the recognition of serious respiratory illness in children. They plan to expand this part of the programme from the hospitals into the community. As well as this they also have community workers who teach mine awareness and basic health education to children, using the "Child-to-child" approach.

As far as training, the IIMT holds a course for "sanitarians" which focuses on public hygiene and sanitation. It seems that some of these students after graduation are employed by the MoPH as environmental health officers but some work as health educators.

Again, in conclusion, this is an area which MEDAIR should pay attention to in the health structures supported but also look further at the training needs, in particular, through the IIMT.

6.5 Drug supplies

All international NGOs consulted use medicines supplied from Europe. PSF use a few medicines and infusions supplied locally whose quality they have tested and are sure of. Some of the NGOs do not import their own drugs but use those provided by PSF, who prefer to supply facilities with NGO support. UNICEF provide vaccines from Canada and also drug kits to some clinics throughout the

country. WHO have used drugs and laboratory reagents from Pakistan and on one occasion had to recall TB medicines because they were found to be ineffective. PSF have analysed some drugs from Pakistan for IFRCS and for example found that the diazepam tablets were composed mostly of sodium bicarbonate.

All international NGOs take care to only import and supply "Essential" drugs.

In the private pharmacies most of the drugs sold are manufactured in Pakistan, India, Iran and China. Sometimes they have European drugs, but also poorer quality exact copies manufactured locally. In addition there are sometimes medicines for sale which had been donated to a hospital or clinic by an international NGO.

Apparently earlier this year, ACBAR held a workshop in Peshawar at which representatives from WHO and AVICEN proposed to import a general stock of medicines with funding from the Dutch government. These medicines would then be available for all NGOs to use. This has not occurred yet and it was not clear what time limit was set.

The MoPH recognises the difficulties in trying to control the quality of drugs used in the country and is taking steps to find a solution. In conjunction with WHO and UNICEF they have drawn up a list of "Essential" drugs for Afghanistan and assisted by WHO they have restarted the quality control laboratory in Jalalabad. At the moment it is only partially functioning.

Hoechst, a German company, has a pharmaceutical factory in Afghanistan but they only make a few of the essential drugs and rather more "luxury" drugs. Their prices are very high, in fact IFRCS found that it was cheaper to import drugs from Europe than buy them in Afghanistan from Hoechst.

In conclusion if MEDAIR is considering providing medicines, they should be imported from Europe so as to ensure good quality or MEDAIR should work in co-operation with PSF.

6.6 Salary versus incentives

Almost all NGOs working in health give incentives to the staff of the clinics and hospitals. As stated above, the salary from the MoPH is very small and is not given on a regular basis. Even with the previous government the salary was not regular. It has been generally observed that performance is improved when incentives are given. AMI had not given incentives as a matter of principle, but have just started to pay the staff in their MCH clinics in acknowledgement of the economic hardships facing the people of Kabul.

However the scale of payment is not the same for all agencies. ICRC pay the highest rate, then most others are around the same. MSF, AMI, MDM, ACF and AVICEN have together agreed on a scale for MCH and other clinic staff. IAM have a payment scale based on US dollars but paid in Afghanis, about twice the amount of the joint scale. AVICEN only have funds at present to give full incentives to staff of the two non-MoPH clinics and small performance rewards to a few staff of the other clinics.

On the other hand TDH employ the midwives on their home-visiting scheme and pay a full salary. When the midwives are hired they are told to resign from the MoPH, so that they are only employed by TDH. However it appears that one or two have tried to draw both salaries, but TDH are dealing with this situation. GMS pay salaries to their TB clinic staff, partly in Afghanis and partly in dry food.

In programmes where the aim is to encourage long-term sustainability, the paying of incentives can be seen to be counterproductive. Unfortunately in the present economic climate and uncertainty in Kabul, it seems to be the only way to ensure that staff actually turn up for work and, in addition, gives the agency some weight of influence in the running of the health facility.

For these reasons it is recommended that MEDAIR should pay incentives to any staff of the programmes they support. The salary scale should generally follow that of other NGOs, except that in the tuberculosis programme MEDAIR should consider a higher scale given the infectious risk and

prevalent fears about tuberculosis. In the MoPH pay-scale, such that it is, the staff of the TB Institute reportedly are paid a small percentage more in recognition of the risks.

6.7 Charges for services

This is another contentious issue and agencies differ in their opinions and practices. Within Kabul the clinics supported by most NGOs and MoPH are supposed not to charge for services or for drugs. However, it is widely suspected that most MoPH and some NGO-supported clinics do ask for fees. Certainly some hospitals such as Nazoano and sometimes Malalai have charges for operations, assisted deliveries and other services.

IAM do not charge for services in the MCH clinic but ask for a small payment for the "road-to-health" card. In the Noor eye hospital patients are charged a small (generally affordable) amount for services.

Outside of Kabul it seems that most clinics and hospitals have some system of charges for consultation or drugs, but there are some such as ARCS clinics which do not. There does not appear to be much co-ordination between agencies regarding this issue.

Instituting minimal charges for health services can give those services more of a value to people who may then be less likely to misuse them. The money collected in this way can be recycled into the costs of providing the service thus increasing the likelihood of long-term sustainability.

MEDAIR is proposing to work with the TB Institute in Kabul city and must therefore consider the fact that TB is primarily a disease of the poor and that the MoPH has recommended that TB treatment be provided free of charge to all people. This will need careful monitoring to ensure that it is always applied.

7. Conclusion

Kabul city presently has 22 hospitals, around 33 MCH and 26 general clinics, 7 specialist clinics and 30 feeding centres. Many of these are supported in some degree by NGOs as described above. For general health care the population appears to have reasonable access, although there may well be some minority communities with less access, and certain geographical areas with poor provision.

The needs identified in this report are summarised in table 4 below. Only in certain instances is intervention by MEDAIR recommended.

Identified needs	MEDAIR?	Comments
Hospitals and polyclinics		
1. General support	NO	This should be the responsibility of the MoPH. MEDAIR should only consider this for individual hospitals where there are other reasons for support.
2. Specific support		
• obstetrics & gynaecology	YES	Support of Khair Khana polyclinic to improve the obstetric facilities. Consider helping other polyclinics in the future.
• paediatrics	YES	Support of Khair Khana polyclinic paediatric outpatients. Provision of TB treatment for children to Maiwand hospital. Continue to monitor the paediatric hospitals.
• dental	?	More information needed.
• infectious diseases	?	Possibility of TB inpatient facility - still uncertain.
• psychiatric	?	More information needed. Not an area where MEDAIR has experience.
3. Geographical support	YES	Support of Khair Khana polyclinic in district 15.
MCH clinics		
1. Geographical - Within Kabul	NO	Small gaps in present services could be covered by the NGOs already working here.
2. Geographical - Outside Kabul	?	More information needed on individual districts. (Some areas are inaccessible because of fighting)
Specialist programmes		
1. Malaria and leishmaniasis	NO	Two other NGOs have proposals for this.
2. Tuberculosis	YES	Support of TB Institute and assisting them to open sub-clinics in Khair Khana and Central Polyclinics and Maiwand hospital in co-operation with PSF. Also to co-ordinate with GMS clinic.
Other Issues		
1. Health Information system (collection of statistics)	NO	WHO and UNICEF are assisting the MoPH with this. Also MEDAIR does not have experience in this field.
2. Co-ordination of NGOs	NO	There are several other agencies who are better equipped to tackle this. The MoPH should also be taking an more active role. MEDAIR is also a relative newcomer to Kabul.

Identified needs	MEDAIR?	Comments
3. Training	YES (in future)	MEDAIR should monitor the situation of the IIMT and seek ways to be involved in the training of nurses and midwives especially.
4. Nursing care	YES	Careful attention should be paid to training and supporting the nurses in all MEDAIR supported facilities. See also training needs above. Not a stand alone programme.
5. Health education	YES	MEDAIR should consider the needs for health education in all its health programmes, and also investigate the possibilities of training health educators through the IIMT. Not a stand alone programme.
6. Private health care and private pharmacy regulation	NO	This is the responsibility of the MoPH, who may be beginning to look at it.

A detailed proposals for MEDAIR assistance to the Tuberculosis Institute and Khair Khana polyclinic has been prepared and is available on request.

2. Research Methods

This study was undertaken in Kabul from mid-November 1996 to early January 1997. The information was obtained from interviews with representatives of the NGOs and UN agencies working in health, representatives from the MoPH, directors of hospitals and institutes or their deputies and the staff of various clinics and from reports of previous co-ordination meetings Visits were made to hospitals and clinics in order to see them in usual working conditions and to clarify their location.

MEDAIR wishes to thank all who offered their assistance to this research and gave of their time and knowledge so willingly.

The Taliban capture of Kabul in September 1996 added a new factor into an already complex and fluctuating situation and hence the gathering of accurate data and perspective has been a difficult process. If any information or views have been misrepresented or ignored in this report, the author apologises. The views and conclusions expressed in this report are solely those of the author.

The report is focused on the city of Kabul but brief mention has been made of the services and needs in the province as a whole. For more specific information, further research is recommended.

8. Appendix A

Table 1. Current Health Provision in Kabul City Districts

Dist -rict	Estimated Population	MCH	Polyclinics and Specialist clinics	Hospitals (number of beds)
1	45,000 women 11,000 children 25,000	Behzad	Central Polyclinic Central Laboratory Central Blood Bank	Maiwand (310) Avicenna Emergency (0) Avicenna Chest (6)
2	66,000 women 18,000 children 33,000		Karte Parwan Institute of TB Inst of Malaria & Parasit. Psychiatric clinic	Stomatology (25) Rabia Balkhi (0) ARCS hospital (48) Police Hospital (50)
3	24,000 women 7,000 children 33,000	Jamal Mena		Ataturk (80)
4	Not available	Parwan-e-Sewom Shahrara	Taimani - ARCS Taimani - MSF Orphan Centre	Malalai (140) New Aliabad (150) Jamhuriat (250) Antani (150) State Security (100)
5	28,000 women 7,000 children 16,000	Mirwais Maidan Durahi Paghman Afshar	Kushal Mena Polyclinic	
6	125,000 women 32,000 children 66,000	Karte Seh Qala Bakhtyar Qala Wazir Pul-e-Sokhta Gul Khana Fatematuzahra ? Shohada	Dashte Barchi Moh. Rassallulah Shahid Balkhi Shahid A Wahid	Karte Seh surgery (250) Karte Seh obstetric (10) Karte Seh medical (50)
7	21,000 (may be increasing) women 5,000 children 13,000	Wasalabad Agha Ali Shams Tanicot Dughabad Dehdana Alawuddin	Chelsetoon	–
8	52,000 women 13,000 children 27,000	Shah Shahid Rahmen Mena	Rahmen Mena - ARCS Rahmen Mena polyclinic Chama Beni Hesar	–

Dist -rict	Estimated Population	MCH	Polyclinics and Specialist clinics	Hospitals (number of beds)
9	122,000 women 32,000 children 64,000	Shash Darak Microrayon 3	Yakatoot	–
10	Not available	Char Qala Wazir Abad Bibi Mahro Pradze Wazir Abad Zarghuna	Qala Fatullah Qassabagh/Airport polyclinic. Halo Trust clinic TODAI clinic GMS clinic ICRC orthop. centre SGAA physio clinic	Military (400) Indira Ghandi (250) Wazir Akbar Khan(250) Noor eye hospital (50) Psychiatric hospital (?) Nazoano (25)
11	39,000 women 11,000 children 21,000	Khair Khana Pt 1-AVICEN	Khair Khana Pt 1 - ARCS	–
12	Not available		Pul-e-Cherki Arzan Qimat	
14	Not available		Shakardara Ghaza	
15	238,000 women 62,000 children 125,000	500 families - AMI (Prodze Jadeed) Khodja Boghra Khair Khana Pt 2 Khair Khana Pt 3	500 families - ARCS	Khair Khana polyclinic (52) *Maryam (private)* *Alnisa (private)*
16	68,000 women 18,000 children 36,000	Qala-e-Zamam Khan Microrayon 1	Dehi Khodydad Old Microrayon clinic	–

Table 2. International and Local NGO Involvement

Action Contre la Faim	Nutrition - 30 feeding centres & 3 hospital malnutrition wards	ACF
ACTED	Coal for hospital & clinics	ACTED
Aide Medical Internationale - Afghanistan	9 MCH clinics	AMI - A
Afghan Red Crescent Society	9 polyclinics, 1 hospital	ARCS
Afghan Relief Foundation	Nazoano Hospital	ARF
Afghanistan Vaccination and Immunisation Centre	8 MCH clinics Malalai hospital TBA training Qarabagh hospital	AVICEN
German Agro Action	Rehabilitation of Indira Ghandi Hospital	GAA
German Medical Service	TB and leprosy clinic Nursing support in Wazir Akbar Khan hospital	GMS
Halo Trust	Clinic in Shari Naw, now only women and children	HT
International Assistance Mission	Noor eye hospital and eye clinics in other hospitals Training for eye technicians Training & rehab for visually impaired Physiotherapy School Kabul Nursing assistance in Aliabad Hospital MCH clinic Karte Seh	IAM (Kabul)
International Committee of the Red Cross	Full support of WAK and Karte Seh surgical hospital Partial support to many other hospitals and clinics, for care of war wounded Orthopaedic & limb-fitting workshop	ICRC
International Federation of the Red Cross Society	Support of ARCS, including 9 polyclinics in Kabul	IFRCS
International Rescue Committee	Printing of health education materials	IRC (HERC)
Jacob's Well Medical Mission	Have sent containers of medicine and clothing Distributed through IFRCS	JWMM
Kabul Province Reconstruction Organisation	Operate a district clinic in Eastern part of Kabul province	KPRO
Medicins du Monde	New Aliabad hospital Ataturk Hospital (stopped Nov 1996) Pul-e-Sokhti MCH *3 MCH clinics in 1997*	MDM (Kabul)
Medical Refresher Courses for Afghans	Plastic surgery unit in Maiwand hosp. Postgraduate medical training	MRCA
Medicins sans Frontiers	Jamhuriat hospital - surgery & burns Karte Seh 50 bed - medical Burns unit in Indira Ghandi hospital 6 polyclinics	MSF (France)
Norwegian Afghanistan Committee	Dental clinic in Chandalbakis in Kabul province	NAC
Orphans Refugees and Aid International	1 polyclinic in Pul-e-Cherki Support of TODAI clinic	ORA
OXFAM	Planned 6 MCH clinics, but temporarily suspended	OXFAM

Pharmaciens sans Frontiers	Pharmacy support in many hospitals and clinics and supply of cleaning materials *In 1997 laboratory support.*	PSF
	Public health survey / monitoring Medical training	RALSA
Swedish Committee for Afghanistan	Kabul province - health centres and vaccination teams, health education	SCA
Save the Children (US)	ARI programme in 5 hospitals Health education and mine awareness	SC(US)
Sandy Gall's Afghanistan Appeal	Orthopaedic workshop and physiotherapy clinic	SGAA
Shuhada Organisation	? 1 MCH	SO
Terre des Hommes	Home visiting midwives from 5 MCH clinics *(5 more clinics in 1997)*	TDH
	Malaria and leishmaniasis clinic	TODAI
United Nations Children's Fund	Support of MoPH Drug supplies to some MCH clinics and Malalai hospital EPI TBA Training NGO & MoPH workshops	UNICEF
World Food Programme	Supply of food to hospitals	WFP
World Health Organisation	Support of MoPH Drugs and lab reagents to TB Institute Laboratory support to hospitals TBA Training NGO and MoPH workshops	WHO

Table 3. Hospitals in Kabul

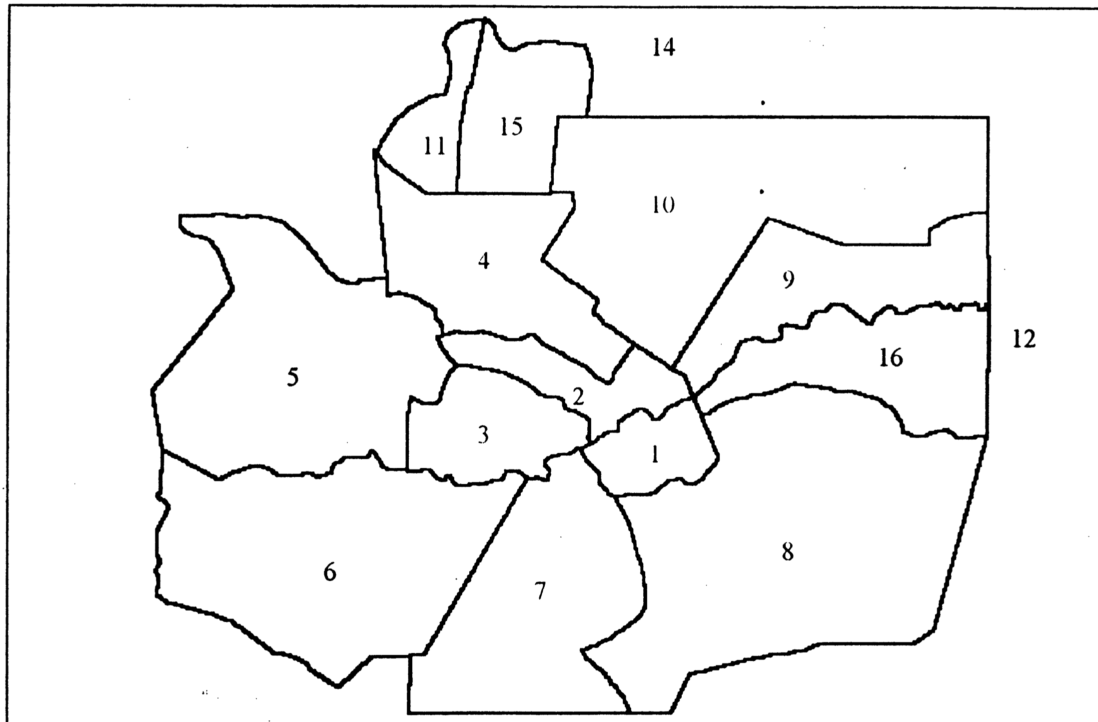
Name	Specialities	Number of beds	Out patients / day	Patients seen	Lab	Xray	No of Doctors	No of Nurses	Total Staff	Electricity	Generator	Water	State of building	NGO's supporting	Comments
Malalai	Obstetrics (Gynae)	140	25-40 deliveries / day	5 - 10	basic	1 machine	80 (almost all female)	16-20	380	yes	yes	yes	Good	AVICEN UNICEF PSF WFP ACTED - Coal *AMI - proposed*	Last year was 120 deliveries / day Incubators but no neonatal Dr
Rabia Balkhi	Obstetrics & Gynae	30 until Sept 96	20-30	none			69 (all female)	47 m/w	254	no	no	?	Fair	PSF ACTED - coal	No surgeon
Nazoano	Obstetric and Gynaecology	25	60-70	4	basic	no	14 (almost all female)	4 midwives	42	yes	?	yes	Good	ARF UNICEF- vaccines ARCS - dressings ACTED - coal	Charge for all services (except vaccination) Offer contraceptive services Can do Caesarian sections
Indira Ghandi	Paediatric - medical - surgical - orthopaedic - nutrition -neonatal - ENT - burns	250		50 (on first visit, more on second visit)	basic but some equipment	1 machine working	100 (m & f)	120	410	yes	yes	?	Improving	PSF ACF - nutrition MSF - burns GAA - rehab ICRC - dressings, Xray film WFP SC(US) - ARI ACTED - coal	Only paediatric surgery facility in Kabul No incubators working
Ataturk	Paediatric - medical - nutrition - ITU	80	40-100	30-40	basic	broken	25 (m & f)	20	130	no	yes	?	Fair Plastic on windows	PSF ACF WFP SC(US) - ARI (MDM - stopped Oct 1996) ACTED - coal	Only part of building is repaired
Maiwand	ENT Plastic surgery Dermatology Ophthalmology Paediatrics - nutrition - medical - infectious	70 20 60 40 120 310	30-35 50-60	8 5 22 3 30 68	basic	3 machines 1 working	51 (m & f)	100	328	no	yes	yes	Good	PSF WHO - leprosy MCA - plastic surgery ACF - malnutrition IAM - eye SC(US) - ARI ACTED - coal	Building was rehabilitated in 1992 MDM supported paediatrics until 1995 Can admit children with TB but no treatment
Khair Khana "52 bed polyclinic"	Internal Medicine Surgical Obs & gyne Paediatric Dental ENT Ophthalmology	50 beds until Sept 96 24 hour emergency care only	200-220	20 in OPD	basic	2 machines 1 working	53 (m & f)	57	240	1-2 hours	yes	hand pump	Good	PSF SC(US) - ARI IAM - ophthalmology ACTED - coal	Maternity unit - normal deliveries only
Avicenna Emergency	Internal Medicine Surgery	60 until Sept 96	25-30	5	basic	1 machine	6 female 34 male	67	261	no	?	?	Fair	PSF WHO (ICRC - stopped when IPD closed) ACTED - coal	Hardly functioning at all
Avicenna Chest	Heart & Lung disease Cardiac surgery	6 (only male)	30-60	6 in IPD 3 in OPD	basic	?	20 (3 female, 8 specialist)	20 female 35 male 55 total	230 (MoPH)	no	yes	?	Good	PSF UNICEF - fuel ACTED - coal	Defibrillator - not used Has been run down for some time

Table 3. Hospitals in Kabul

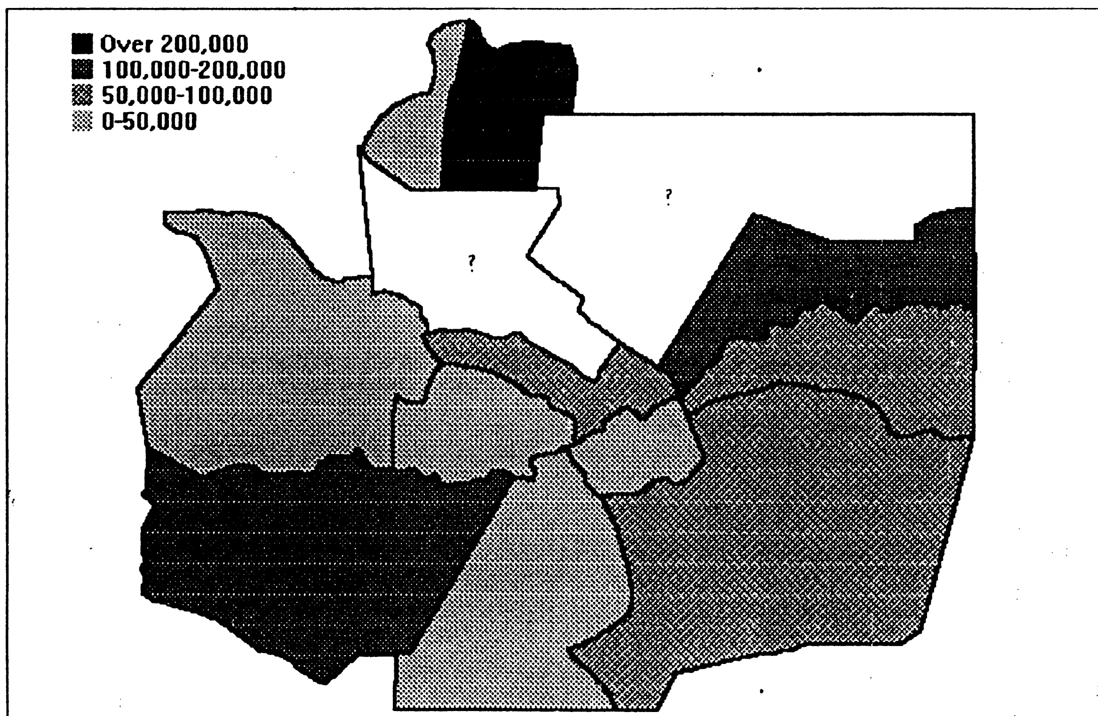
Name	Specialities	Number of beds	Out patients / day	Patients seen	Lab	Xray	No of Doctors	No of Nurses	Total Staff	Electricity	Generator	Water	State of building	NGO's supporting	Comments
Antani	Infectious Diseases	150 seasonal variation	?	10	basic	Portable - never used	50 6 female	60		yes	yes 10 kW	yes	Good	PSF MSF - water, 6 months ago ACTED - coal	Separate partially finished building (for TB patients ?)
ARCS	Internal medicine Surgery	48	50-60	25	basic	1 machine + ECG	9 3 surgeons 6 physicians	12	48	no	yes	?	Fair Plastic on windows	IFRCS occasional ICRC - occasional IV fluids	All treatment provided free, but very few drugs.
Karte Seh Surgical	Surgical	250				yes				no	yes			ICRC - full support	
Karte Seh Maternity	Obstetric	10, was 50	25-35		basic	no	3 (from Malalai)	7		no	no	hand-pump	Good	ICRC - dressings etc	Refer to Surgical hosp at night, Malalai in daytime
Karte Seh Medical	Internal Medicine	50	80-100	30	basic	no	20 (1 female)			no	yes	yes	good	MSF WFP ACTED - coal	Separate OPD for men and women
Jamhuriat	Surgery Internal Medicine Burns unit (adults)	250		~140	haem, bact & biochem	2 machines 1 working ECG x 2	100 (10 female)	100-120	400 (MoPH)	yes	yes 3	yes	Good	MSF - surgical & burns unit PSF WFP ACTED - coal IAM was training surgeons	Good operating facilities Endoscopy Wards all warm
New Aliabad	Surgery - general Neurosurgery Urology Internal Medicine	165			haem, bact & biochem	yes	80	137		yes	yes 3	yes	good	MDM - fuel & drugs ICRC - dressings PSF - for medical wards IAM - nursing ACTED - coal	Said to be working well Not visited Rehabilitated by MDM in 1995
Wazir Akbar Khan	Surgery Orthopaedics Internal Medicine	250				yes				yes	yes	yes	Good	ICRC - full support for surgery PSF - for medical wards GMS - nursing	Not visited
Military "400 beds"	Orthopaedics Surgery Internal Medicine ?? Paediatrics	400	60		good	yes	70 ?			yes	yes	yes	Good	Ministry of Defence ICRC - partial support MDM - paediatric - stopped Feb 96	Not visited Open to men only Paediatric ward reportedly closed
State Security	Surgery Internal Medicine	100 (now closed)	10		basic	yes	50			yes	yes	yes	Needs repair	Ministry of Security ICRC - partial support	Not visited Treats detainees and the public
Police	Surgery Internal Medicine ENT surgery	50	10		basic	yes	30	30		yes	yes	yes	Fair	Ministry of Interior ICRC - partial support	Not visited
Stomatology	Dental Maxillary-facial and neck surgery	25	80		not working	not working	15		286	no	yes	hand pump	Good	PSF ICRC - dressings ACTED - coal	Need specific dental supplies
Noor Eye Institute	Ophthalmology	50												IAM - full support ACTED - coal	Not visited
Psychiatric	Psychiatry	?												PSF ACTED - coal	Not visited Was part of Aliabad
Qarabagh	Surgery Internal Medicine Paediatrics	30	150											(IMC - stopped Sept 96) AVICEN	Presently on front line

9. Appendix B

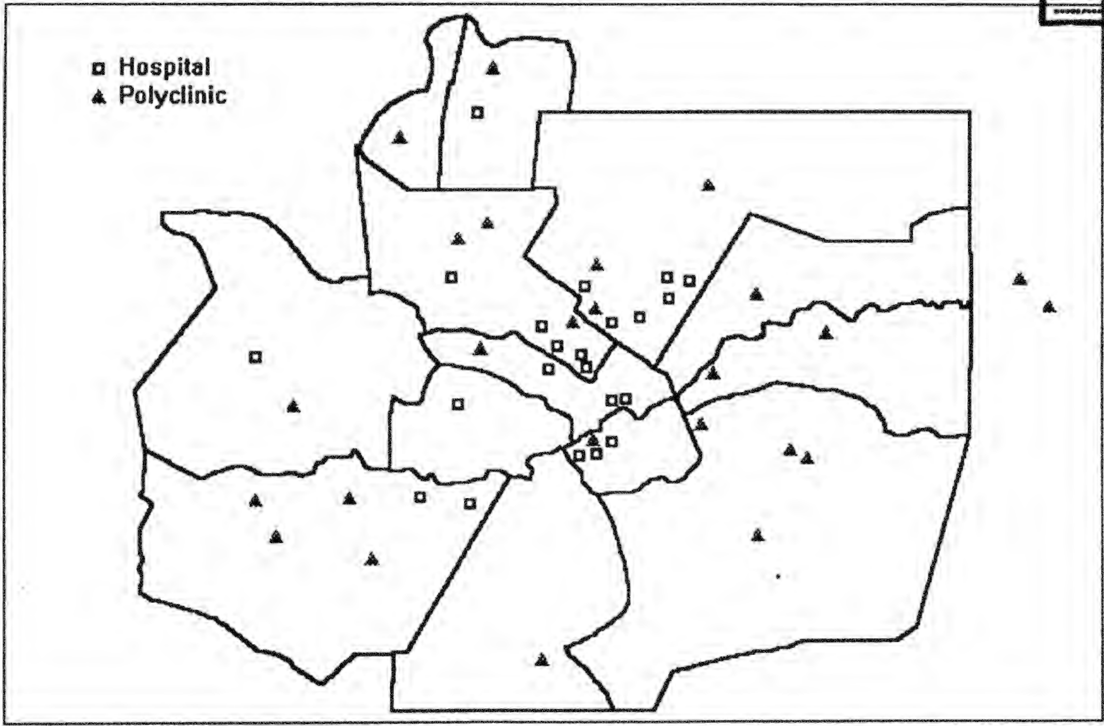
Map 1 - Districts of Kabul



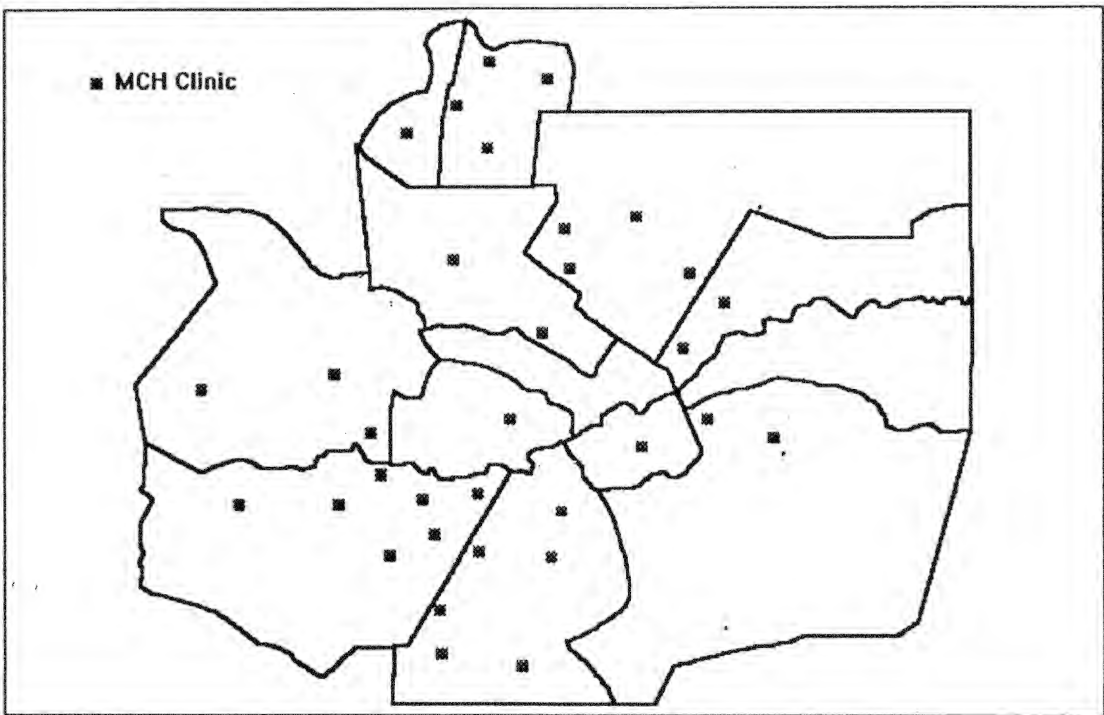
Map 2 - Population by District



Map 3 - Locations of Hospitals and Polyclinics



Map 4 - Locations of MCH Clinics



3. Background Information

Afghanistan has suffered 18 years of civil war which have completely disrupted whatever public health facilities and organisational structures that had previously existed.

Under the communist government the cities had reasonable hospitals and polyclinics but the rural areas were mostly under mujahadeen control and so had generally poor facilities, if any. Various NGOs provided health care in cross-border operations and training for the refugees in Pakistan. Apparently there were good vertical programmes for the control of malaria, leishmaniasis and tuberculosis run by the appropriate national institutes. The structure went from the national institute in Kabul to regional specialist centres with inpatient facilities, to district level with provincial centres and facilities integrated into the basic health units for simple diagnosis and treatment. Foreign governments supported some medical facilities, for example Japan had provided extensive support to the tuberculosis Institute, India provided the Indira Ghandi paediatric hospital and sent Indian specialists to help with training.

With the Islamic Revolution in 1991 and the consequent fighting between the government of Rabbani and Hezbi-e-Islami and Hezbi-e-Wahdat forces, most of the remaining facilities were destroyed or left with very little financial support. Kabul was divided between the factions who each tried to provide some health services, aided in some cases by NGOs. The Kabul population suffered high casualties from the factional fighting and again in the past two years from the rocketing between government and Taliban forces. For medical services the greatest priority was the treatment of war wounded and in order to give access to all wounded people ICRC supported hospitals on both sides of the front-line which at one time ran through the centre of the city. There was little co-ordination between the Ministry of Public Health (MoPH) which only had jurisdiction over part of the city and the NGOs, and certainly none between the opposing factions. ACBAR, a coordinating agency, had implemented some medical co-ordination meetings between NGOs and the situation had begun to improve recently.

However this situation changed again in September 1996 when the Taliban swept virtually unopposed into Kabul. Now the city and districts are all under the control of the MoPH and after a couple of months of adjusting to the changes they are now attempting to take a more active role in co-ordination. There are still a few clinics run by the Ministry of Rehabilitation and Rural Development on the outskirts of the city. Some of the clinics which were previously run by other political parties are now seeking registration under the MoPH.

The daily rocketing of the city has stopped and apart from occasional aerial bombing by Masood or Dostum planes there is comparative peace. However the war casualties do not stop. Injured soldiers and civilians from the fighting in the north of the province are being brought to the surgical hospitals and there are still civilians, often children, killed or injured by mines and unexploded ordinances. Before the arrival of the Taliban in Kabul, 22-25 people were killed or injured each month by mines in the city. In the first month after their take-over there were 85 victims.

The destruction of public infrastructures and displacement of people with subsequent overcrowding has led to an increase in diarrhoeal and other communicable diseases, such as tuberculosis, and vector borne diseases, such as malaria and leishmaniasis. There have been periodic cholera epidemics in the summer months throughout Afghanistan. The last cholera epidemic in the central region was in 1994.

Assuming some political stability now prevails, it will be a good opportunity for the MoPH to bring much needed co-ordination to the public health services, and to lift the focus from curative services to education and prevention.

3.1 The Ministry of Public Health

In the two months of the survey and writing of this report, there have been considerable changes of personnel in the MoPH. Several heads and deputies of departments have departed and the new Minister

of Public Health is the second to hold the office. However, since January 1997, the MoPH appears to have more direction, provided by the new Minister.

Although the MoPH is responsible for co-ordinating all health facilities and employment of all staff, no-one in the MoPH was able to supply an accurate list of hospitals and clinics. (Nor, for that matter, was anyone else).

The average working day at the MoPH is from approximately 9am until 12pm. Similar to many government offices the majority of the secretarial staff are female and therefore no longer able to work. This contributes to inefficiency of the ministry.

WHO and UNICEF have been working closely with the MoPH in providing technical and financial assistance to the ministry and support for more than 40 projects. At the end of December 1996 they held workshops in Peshawar and Kabul to formulate a "Joint Action Plan for 1997". Most NGOs working in health were not included in these workshops, a fact which has not improved co-ordination between MoPH, WHO, UNICEF and the NGO community.

The two UN agencies have also been working with the MoPH to prepare standard forms for the reporting and collection of medical statistics but this has not been completed yet.

At a co-ordination meeting with all the foreign and local medical NGOs and the MoPH on 8th January the new minister, His Excellency, Mullah Abbas, outlined their plans for rationalising the existing hospitals in Kabul and for developing completely separate hospitals for men and women. They also want to restart the provincial hospitals and district clinics in the provinces of the central region and he appealed to the NGO community for assistance. Other areas that the MoPH is seeking to address are the quality control of the medicines sold in private pharmacies or dispensed in public health facilities, and the problem of private medical services offered by unqualified people.

3.2 Medical demography

There are very few medical statistics for Afghanistan and Kabul as many of the structures needed for data collection do not exist or have been disrupted by the years of war. However WHO give the following estimates of health and health related statistics for the whole country.

Population	19 million
Crude birth rate	48 / 1,000
Crude death rate	28 / 1,000
Annual growth rate	2.5%
Life expectancy at birth	male 43 years female 44 years
Infant mortality rate	182 / 1,000 live births
Under-five mortality rate	250 / 1,000 live births (5th highest in the world)
Maternal mortality rate	1,700 / 100,000 live births (2nd highest in the world)
Fertility rate	6.9 deliveries per woman
Deliveries attended by trained health personnel	9%
Deliveries attended by trained TBAs	less than 6%
% of deliveries at home	90%
% of infants with low birth weight	20%
Children receiving MCH care	18%
% population with access to health services	29%
% population with safe water	10%

Leading causes of infant mortality	Diarrhoeal diseases Acute respiratory infection Malnutrition
Leading causes of mortality (all ages)	1. Diarrhoeal diseases 2. Malaria 3. Pulmonary tuberculosis 4. Measles 5. Acute (but ill-defined) cerebrovascular disease 6. Bronchopneumonia 7. Peritonitis 8. Burns and accidents caused by firearm missiles 9. Postpartum haemorrhage
Leading causes of morbidity	1. Diarrhoeal diseases 2. Cataract 3. Bronchopneumonia 4. Chronic disease of tonsils and adenoids 5. Malaria 6. Intracranial injury 7. Asthma 8. Amoebiasis 9. Other disorders of the eye 10. Tuberculosis 11. Skin diseases 12. Leishmaniasis
Total number of cases of malaria in 1995	250,000 cases
% due to P. Falciparum	26%
Annual risk of TB infection	2-3%
Total number of all forms of TB	76,000 - 115,000 cases 70% of these are women

The above information was endorsed in general terms by most agencies spoken to, although there were questions about the reliability of figures given the extreme difficulties of collecting accurate data in Afghanistan.

At this time there is no health information system in place in Afghanistan and there is no co-ordination between NGOs in the compilation of statistics. In December 1996 WHO and UNICEF worked jointly with the MoPH to develop a framework and methods to collect and collate health statistics but the results (e.g. reporting forms) have not yet been distributed to the health facilities and NGOs.

4. Current Health Provision in Kabul City Districts

Kabul city has been divided up into administrative districts numbering 1-12 and 14-16. For ease of reference in this report the location of any health facility will be given by the district number. However for the people in some areas the nearest clinic or hospital may actually be in an adjacent district. This can be seen from the maps in Appendix B which show the outlines of the districts with the approximate locations of the health structures.

Table 1 (Appendix A) shows the distribution of MCH clinics, general and specialist clinics and hospitals by districts. Even those who work in the clinics are not always exactly sure of where they are, so the table may not be completely accurate. In addition some clinics are called by two or three different names by different people. For these clinics the most common name has been used.

In district 15 two private clinics with inpatient facilities have been included as these were referred to by several people. There are certainly other private clinics in other districts but very little information was obtained about them.

In the table the populations of the districts have been estimated from surveys by Habitat. The accuracy of these figures is difficult to assess and particularly now that the rocketing has ceased and some people are returning to their previous areas. Nobody appears to have any population figures for districts 4 and 10, both of which are fairly densely populated. The total population of Kabul city is estimated at 1.2 million.

4.1 International and local NGO involvement

Many of the health facilities listed in table 1 are supported in some measure by international NGOs and a few by local agencies. Three UN agencies are also involved. In addition some agencies are running other health programmes. Table 2 in Appendix A summarises the agencies and their programmes.

5. Health Facilities

This review of health facilities looks at hospitals, polyclinics, mini-health centres, mother and child health clinics, nitritional care, EPI coverage and specialist clinics.

5.1 Hospitals

5.1.1 Description

There are 22 "public hospitals" in Kabul city and one hospital in Qarabagh in the north of the province. As with many health facilities these vary greatly in size and capability.

In the past four years as the fighting has shifted inside and around Kabul, the hospitals in different areas have received many war wounded and therefore a large input from the NGOs on a fluctuating basis. Also the population concentrations have shifted from area to area. Some of the hospitals such as Khair Khana polyclinic have developed from polyclinics to busy inpatient departments and back to polyclinics within the space of 2 or 3 years. Some such as Aliabad, Maiwand and Ataturk have moved location a few times.

Following the latest change of government in September 1996, the directors of several hospitals have changed for political reasons and the financial circumstances of almost all have deteriorated as the MoPH has had no money and has lacked direction.

Several hospitals such as Maiwand, New Aliabad and the military hospital have had assistance with the rehabilitation of buildings and restoration of equipment from international NGOs within the past 2 years and so are in quite a good state.

Table 3 (Appendix A) gives a breakdown of the hospitals by speciality, with information on number of beds, facilities and staff. This information was obtained by visits to the hospitals and interviews with the director or deputy, by interviews with other agencies and MoPH and from the report of a meeting of health NGOs earlier this year. For those hospitals visited the number of patients seen is recorded and it can be seen that in all these hospitals the utilisation of beds was below their stated capacity. However during the summer months the number of inpatients will increase. This is mainly due to the increase in diarrhoeal and infectious diseases.

The numbers of staff given have not been verified but were taken to be the approximate number of staff theoretically employed in the hospitals and definitely not the number of staff who would be present at their jobs on any one day. Many hospitals operate on a shift system with teams of doctors and nurses on duty for 24 hours at a time.

The table is not complete and may contain mistakes as each agency and the MoPH have different lists and it was not possible in the time given to visit each hospital and verify its existence. It is hoped that further information will be gained in the coming months.

Although Khair Khana is now a polyclinic, it has been included in this table because until recently it supposedly had 52 inpatient beds and was regarded as a hospital. It is also the only polyclinic at this time with obstetric facilities of any sort.

5.1.2 NGO involvement

There is a high degree of NGO aid to the hospitals without which many of them would not be able to function. The agencies involved in individual hospitals are shown in the table 3 (Appendix A).

It is not clear what co-ordination there is between the NGOs working within the same hospital and it is assumed to be on an informal basis between the individuals in each agency. The role of the hospital management in all this is also not clear. However it has been observed that when a hospital receives support for any one speciality, the supplies and drugs are nearly always used in other wards as well.

The Minister of Public Health recently expressed his desire that NGOs would support hospitals completely rather than specific areas. There has not been any response from the NGOs to this statement as yet.

ICRC and MSF are well prepared for emergencies. ICRC keeps an emergency stock of surgical supplies sufficient for 8 months. MSF has emergency stocks sufficient for 6 months, in addition to the resources to treat 500 patients with cholera. Most other agencies have limited buffer stocks.

5.1.3 Issues / needs assessment

In general it can be stated that the hospitals with support from international NGOs (or military) are able to deliver a reasonable service while those with no support are struggling to continue, especially through the winter.

For the purposes of discussion the needs of the hospitals can be divided into two categories:
- General support - the running costs in food, fuel, staff incentives, general equipment;
- Specific support - the facilities, equipment, training, management support for a particular speciality.

5.1.3.1 General support

The main problems are a lack of salaries and transport for the staff (since September 1996 until the end of December most health staff have only received one month of an already inadequate salary), lack of fuel to heat the buildings and run the generators, and lack of food for the inpatients. This is despite the fact that ACTED are supplying coal to many hospitals and clinics and WFP are supplying food in the form of wheat flour, sugar, ghee and lentils. Before September 1996 the MoPH was able to supply small amounts of fuel to the hospitals to enable them to run their generators and give some money towards the purchase of drugs but this has not occurred since the Taliban took over the city. In the past 3 months, 3 hospitals, Avicenna Emergency, Rabia Balkhi maternity and Khair Khana polyclinic have closed their inpatient facilities. Although none of them were running at full capacity, it is indicative of the general deterioration. According to verbal reports Malalai maternity hospital is now functioning at only half the activity level of earlier this year due to insufficient resources.

Another problem is that there is no efficient referral system between clinics and hospitals, even though there are specialist hospitals. Although a patient who is in need of specialist expertise may be provided with a letter to the relevant hospital, this is an informal and unreliable system. Often the patient is simply told to go to the specialist hospital. Furthermore they are responsible for their own transport and may not be able to afford it. People usually go to a hospital where they know someone on staff who will make sure they receive care.

5.1.3.2 Specific support

For a detailed listing of agencies and the specific support they provide see Tables 2 and 3 (Appendix A).

ICRC, MSF and MDM provide good assistance to the surgical hospitals. Medical care is also reasonably provided for - general medical needs of most hospitals benefit indirectly from the support given to the surgical wards, as well as from PSF (who supply medicines) and MSF (who support Karte Seh).

Two specialities which appear to have more needs are the paediatric and obstetric and gynaecology services - accordingly these are discussed in more depth below. Specialist hospital are also briefly discussed.

Paediatrics

There are three hospitals with paediatric facilities.

Although **Indira Ghandi** hospital has many NGOs supporting it, they are in fact each only concerned with one specific area. GAA is rehabilitating the building, ACF runs a therapeutic feeding ward, MSF assists the burns unit, PSF supplies the pharmacy and ICRC has given some dressing materials and Xray films. The medical, surgical, orthopaedic, ENT and neonatal wards and OPD are not supported apart from the ARI (Acute Respiratory Infection) programme run by SC(US). This involves incentives for a small number of staff and the supply of some relevant medicines during the winter months. The neonatal ward has no working incubators or other equipment. The first time this hospital was visited there were only a few patients and it seemed generally very run down and with poor equipment. On a second visit it was busier and much brighter and cleaner due to the work of GAA, but the situation with equipment remains the same, although there is a possibility that one agency will be able to supply some equipment.

Ataturk hospital was receiving quite a large amount of support from MDM but the 6 month contract finished in October 1996 and was not renewed because of reported differences of opinion between the agency and the doctors of the hospital. MDM have repaired one part of the building which is now being used for wards but extensive repairs are still needed in the other parts. They also provided drugs, equipment and fuel. The hospital is also assisted by ACF, PSF and SC(US) and seems to be running well at the moment but it is hard to predict how long they can maintain this with less NGO assistance.

Maiwand hospital has a paediatric department supported by ACF for the malnutrition ward and SC(US) for the ARI programme. PSF supply medicine for the hospital generally. This is the only hospital which has an infectious diseases ward for children. They sometimes admit children with tuberculosis, but cannot provide the necessary medicines.

Obstetric and gynaecology

Malalai is the only public maternity hospital that is able to provide care for complicated deliveries for the whole of Kabul (city and province). In 1995 AVICEN were able to rehabilitate the building and build a large water tank as well as supply equipment and drugs. At the moment they still help with a small amount of drugs and PSF also supply drugs, but according to the director it is not enough for their needs. This is also the only hospital that is able to do any gynaecology, but at the moment they only deal with emergency cases. Due to a lack of funds they sometimes charge a fee for treatment. They have 10 working incubators but no paediatric doctors. They often receive very difficult cases made worse by the distance that many women have to travel to reach them.

Rabia Balkhi hospital was the other main obstetric hospital in the past, but it was closed from 1992 until early 1996. In the beginning of 1996 it was opened up again with 30 beds but even then there was no surgeon to do Caesarian sections and so they were only able to deal with normal deliveries. Unfortunately even this facility was closed down after September 1996 and now they only run an OPD.

Karte Seh obstetric unit is next to the surgical hospital and is only able to look after normal deliveries in the unit but they can refer women for Caesarian section to the main surgical hospital in an emergency. Otherwise they send the women with difficult deliveries to Malalai hospital.

Nazoano hospital, although run by an Afghan NGO, is essentially running as a private hospital and has facilities for operative deliveries.

Khair Khana polyclinic also used to have a referral obstetric facility as did Central, Rahmen Mena and Kushal Mena polyclinics at the time of the communist government. Now the latter three polyclinics do not have any facilities for deliveries and Khair Khana are only able to assist with normal deliveries. As they only have female staff during the daytime, any deliveries at night time are essentially unassisted. There are also two private clinics in Khair Khana which are said to have obstetric facilities, but charge considerable fees which are beyond the means of most people.

Specialist hospitals

There are some other specialist hospitals that are said to be in need of further assistance. These are the stomatology hospital, Antani infectious diseases hospital and the psychiatric hospital.



AFGHANISTAN

TITLE

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RESEARCH REPORT PREPARED BY

MEDAIR, Afghanistan

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